VERMONT

Office of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, Vermont 05495

Agency of Human Services

~BUPRENORPHINE ~

Prior Authorization Request Form

Vermont Medicaid has established criteria for prior authorization of buprenorphine (Suboxone®, Subutex®). These criteria are based on concerns about safety and the potential for abuse and diversion. For beneficiaries to receive coverage for Suboxone® or Subutex®, it will be necessary for the prescriber to telephone or complete and fax this form to MedMetrics Health Partners. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

Submit request via: Fax: 1-866-767-2649 or Phone: 1-800-918-7549

Prescribing physician:

Name:_____

Phone #:_____

Fax #:_____

Address:_____

Beneficiary:

Name:_____

Medicaid ID #:_____

Date of Birth:_____ Sex:_____

Diagnosis:_____

Contact Person at Office: _____

Pharmacy (if known)**:**_____ Phone:_____ &/or FAX:_____

QUALIFICATIONS

MD/DO	Prescribers must have a DATA 2000 waiver ID ('X' DEA license) in order to prescribe.
Patients	Patients must have a diagnosis of opiate dependence confirmed.

PROCESS

► Answer the following questions:

Is buprenorphine being prescribed for opiate dependency?	□ Yes □ No
Does the prescriber signing this form have a DATA 2000 waiver ID number ("X-DEA license")?	□ Yes □ No
Request is for the following medication:	□ Suboxone® (buprenorphine/naloxone) □ Subutex® (buprenorphine)
Anticipated maintenance dose/frequency: Dose:_____Frequency:_____	
If this request is for Subutex®, please answer the following questions: Is the member pregnant? If yes, anticipated date of delivery: _____	□ Yes □ No
Does the member have a documented allergic reaction to naloxone that has been witnessed by a health care professional? If yes, please provide medical records documenting the allergic reaction.	□ Yes □ No
Additional clinical information to support PA request:	

Prescriber Signature: _____ **Date of request:** _____